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Author(s): Walter R. Gove

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SOCIETAL REACTION AS AN EXPLANATION OF MENTAL ILLNESS: AN EVALUATION *

WALTER R. GOVE

Vanderbilt University

The societal reaction perspective, which sees stabilized deviant behavior as being primarily a consequence of the reactions of others, has been very much in vogue during the 1960's. This perspective, however, has received little systematic evaluation. This paper is an attempt to meet the lack of critical evaluation by examining the evidence in a particular area of deviance—that of mental illness. The evidence strongly suggests that the societal reaction explanation of how and why persons enter the mentally ill role is incorrect, for it appears that there is a fairly rigorous (if largely informal) screening process and that the substantial majority of persons who are hospitalized are suffering from a serious disturbance. Furthermore, the societal reaction theorists would appear to have greatly overstated the degree to which secondary deviance is associated with mental hospitalization.

DURING the 1960's the societal reaction perspective, sometimes referred to as "labeling theory," has been one of the most pervasive and influential sociological approaches to deviance.¹ However, this perspective has re-

ceived little systematic evaluation. In this paper I will attempt to assess the empirical validity of the explanation of mental illness provided by the societal reaction theorists.

THE SOCIETAL REACTION PERSPECTIVE

One of the most fundamental distinctions made by the societal reaction theorists is between primary deviance, which may cause someone to be labeled as a deviant, and secondary deviance, which is the behavior produced by being placed in a deviant role. Regarding primary and secondary deviance, Lemert (1967:17) says:

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¹ Some of the most important statements of this approach are Lemert 1951, 1967; Becker, 1963; Scheff, 1966; Erikson, 1957, 1964; Kitsuse, 1964; Goffman, 1961; Schur, 1969.

"Primary deviation is assumed to arise in a wide variety of social, cultural, and psychological contexts, and at best has only marginal implication for the psychic structure of the individual; it does not lead to symbolic reorganization at the level of self-regarding attitudes and social roles. Secondary deviation is deviant behavior, or social roles based upon it, which becomes a means of defense, attack or adaptation to the overt and covert problems created by the societal reaction to primary deviation."

The societal reaction theorists do not appear to attach significance to an act of primary deviance except insofar as others react towards the commission of the act. To them deviance is not a quality of an act, but instead deviance is produced in the interaction between a person who commits an act and those who respond to it (Becker, 1963:14). As Erikson (1964:11) says: "Deviance is not a property *inherent* in certain forms of behavior; it is a property *conferred upon* these forms by the audiences which directly or indirectly witness them. The critical variable in the study of deviance, then, is the social audience rather than the individual actor, since it is the audience which eventually determines whether or not any episode of behavior or any class of episodes is labeled deviant." Similarly Becker (1963:9) states: "*Social groups create deviance by making rules whose infractions constitute deviance*, and by applying those rules to particular people and labeling them as outsiders. From this point of view, deviance is not a quality of the act a person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender.' The deviant is one to whom the label has successfully been applied; deviant behavior is behavior that people so label." Becker goes on to emphasize the distinction between rule breaking and deviance, noting that many persons who commit rule-breaking acts do not receive a deviant label while others, who have committed no rule-breaking act may, by mistake, be labeled deviant.

Persons do not usually commit acts that would place them in a deviant status without some reason. Although the societal reaction theorists have not been particularly concerned with explaining acts of primary deviance, they have provided a number of explanations of why a person might commit such acts. (1) A person may belong to a minority group or subculture whose values and ways of behaving may lead to violations of the rules of the dominant group. (2) He may have conflicting responsibilities, and the adequate performance of one role may produce violations in a second role. (3) He may violate rules for personal gain, usually with the expectation that he won't be caught. (4) He

may be simply unaware of the rules and violate them unintentionally. Primary deviance is thus attributed to inconsistencies in the social structure, to hedonistic variables or to ignorance, while psychological characteristics such as personality or psychiatric disorders are ignored.² What concern the societal reaction theorists have with an individual's personal and social attributes is focused on how these attributes affect the way others respond to an act of primary deviance. Their argument is that the more powerful a person, the less likely the deviant label will be imposed upon him.

According to this approach, usually the most crucial step in the development of a stable pattern of deviant behavior is the experience of being caught and publicly labeled deviant. Whether or not this happens to a person "depends not so much on what he does as on what other people do"³ (Becker, 1963:31). Erikson (1964:16), writing about the public labeling process, states: "The community's decision to bring deviant sanctions against the individual . . . is a sharp rite of transition at once moving him out of his normal position in society and transferring him into a distinctive deviant role. The ceremonies which accomplish this change of status, ordinarily, have three related phases. They provide a formal confrontation between the deviant suspect and representatives of his community (as in the criminal trial or psychiatric case conference); they announce some judgment about the nature of his deviancy (a verdict or diagnosis for example), and they perform an act of social placement, assigning him to a special role (like that of a prisoner or patient) which redefines his position in society."

Erikson (1964:16) goes on to state: "An important feature of these ceremonies in our own culture is that they are almost irreversible."⁴ Why might this be the case? According to the societal reaction theorists, the status of deviant

² For the exception to this otherwise apparently uniform trend, see Lemert (1967:55-59).

³ Becker does note the possibility that the person might brand himself as "deviant" and "punish himself."

⁴ Becker (1963:37) notes that in the situation where a person is apprehended for the first time, the act of apprehension does not necessarily lead to secondary deviance if the person is still in a position to choose alternative lines of action. Similarly, Lemert (1967:42) indicates that the importance of degradation rituals is not in their drama but in their consequences and that "for stigmatization to establish a total deviant identity it must be disseminated throughout the society." In any case, it would appear that when a person's mental disorder leads to a public hearing which results in hospitalization, that person has no alternative lines of action and that his "deviance" is well established.

is a master status which overrides all other statuses in determining how others will act towards one (Becker, 1963:33). Once a person is stigmatized by being labeled a deviant, a self-fulfilling prophecy is initiated with others perceiving and responding to the person as a deviant (Becker, 1963:34; Erikson, 1964:16). Furthermore, once persons are publicly processed as deviants, they are typically forced into a deviant group (usually by being placed in an institution). As Becker notes (1963:38), such groups have one thing in common, their deviance. They have a common fate, they face the same problems and because of this they develop a deviant subculture. This subculture combines a perspective on the world with a set of routine activities. According to Becker (1963:38), "membership in such a group solidifies a deviant identity" and leads to rationalization of their position.

In the view of the societal reaction theorists, once this has occurred it is extremely difficult for the person to break out of his deviant status. As Lemert (1967:55) states, "Once deviance becomes a way of life the personal issue often becomes the cost of making a change rather than the higher status to be gained through rehabilitation or reform. Such costs are calculated in terms of the time, energy and distress seen as necessary for change." The deviant has learned to carry on his deviant activities with a minimum of trouble (Becker, 1963:39). He has already failed in the normal world, suggesting to himself and others an inability to make it even when things are relatively normal; now he faces the world as a stigmatized person. If he is in an institution, such as a mental hospital, to become a candidate for reinstatement in society he must, as Lemert (1967:45) notes, give allegiance to an often anomalous conception of himself and the world. Denial of the organizational ideology may lead to the judgment that the deviant is "unreformed" or still "sick." Even if he is returned to the community, he presumably will face an audience which anticipates the worst and which will take steps to protect himself, steps which make it difficult for the person to succeed. Furthermore, in the community he may be on a form of probation which forces him to live by extremely rigorous rules, the violations of which are grounds for reinstitutionalization.

In summary, the argument of the societal reaction theorists is that persons who have passed through a degradation ceremony and have been forced to become members of a deviant group have experienced a profound and frequently irreversible socialization process. They have acquired an inferiority status and have developed a deviant world view and the knowledge and

skill that go with it. And perhaps equally important, they have developed a deviant self-image based upon the image of themselves they receive through the actions of others. Although the societal reaction perspective of deviance has been very much in vogue during the 1960's, most of the work based on this perspective has been intuitive and/or theoretical, and there has been very little systematic evaluation and testing of the perspective. What follows in this paper is an attempt to meet this lack of critical evaluation by examining the evidence in a particular area of deviance—that of mental illness.

ENTRANCE INTO THE MENTALLY ILL ROLE

The Theoretical Explanation. A fairly explicit statement of how the societal reaction perspective may be used to explain how a person becomes mentally ill has been provided by Scheff.⁵ Following Becker, he makes a distinction between rule-breaking and deviance. He then goes on to note that: "the culture of the group provides a vocabulary of terms for categorizing many norm violations: crime, perversion, drunkenness, and bad manners are familiar examples. Each of the terms is derived from the type of norm broken, and ultimately, from the type of behavior involved. After exhausting these categories, however, there is always a *residue of the most diverse kinds of violations* for which the culture provides no explicit label" (*italics added*), (Scheff, 1966:34).

Scheff terms these types of violations residual rule-breaking and then indicates that it is the violation of these diverse kinds of rules that lead to labeling someone mentally ill. He notes that "we can categorize most psychiatric symptoms as instances of residual rule-breaking or residual deviance" (Scheff, 1966:33). Throughout the remainder of his work he equates the diverse behaviors of residual deviance with the symptoms of the mentally ill. According to him (Scheff, 1966:40) there "should be an unlimited number of sources" of residual rule-breaking. In giving an example of residual rule-breaking, he discusses Goffman's (1964) position that there is a rule that the adult be "involved" when in public view. According to Scheff (1966:34-39), if a person is uninvolved or "away" without giving the appropriate signals, he is a residual rule-breaker. Other examples of residual rule-breaking presented by Scheff are the Dada movement and the reactions to LSD-25, to monotony, and to sleep and sensory deprivation.

⁵ It should be clear by now that mental illness, as Scheff and other societal reaction theorists use the term, refers to the occupancy of a social role and not to a state of personal distress or disorganization.

Scheff holds that: (1) acts of residual rule-breaking are frequent and they are committed by a very wide segment of the "normal" population; (2) they are caused by very diverse (and frequently benign) factors; and (3) they should not be taken to indicate personal abnormality or disorder. Scheff's point appears to be that we do not need to be concerned with the act of residual deviance or its cause, but that instead we need to focus on the reactions of others to acts of residual deviance. Scheff (1966:54) explicitly states that the societal reaction is the single most important factor in the stabilization of mental illness.

To explain the public's reaction to an act of residual rule-breaking, Scheff turns to the public stereotype of mental illness. He notes that "stereotyped imagery of mental disorder is learned in early childhood" (1966:64) and that these "stereotypes of insanity are continually reaffirmed, inadvertently in ordinary social interaction"⁶ (p. 67). According to Scheff (1966:67) an important component of the public stereotype of insanity is an unreasoned fear of the mentally ill which makes the public unwilling to take risks that would routinely be accepted in ordinary living. He holds that sometimes this stereotype is applied to a person who commits an act of residual rule-breaking and at other times it is not. He notes a general tendency to deny that an act of residual rule-breaking is an indication of mental illness. When denial occurs, residual rule-breaking is presumed to be transitory. However, if for some reason "the deviance of the individual becomes a public issue, the traditional stereotype of insanity becomes the guiding imagery for action" (Scheff, 1966:82). When this happens, it is assumed that procedures to initiate hospitalization will be quickly taken.

Once a person enters the domain of officials responsible for the hospitalization of the mentally ill, it is argued that he will be almost invariably hospitalized. Scheff (1966:105-155) presents a number of reasons for this position based upon his research. (1) Psychiatrists are more sensitive to signs of mental illness than the general public; they tend to see a broad array of persons as disturbed and in need of care. (2) Once the question of whether or not a person is ill has been raised, officials, following the medical ideology, feel that it is safer to treat someone

who may not be ill than it is to release someone who may be ill. And (3) there are a number of features built into the commitment process, such as established routines, lack of facilities, the payment schedule for examiners, etc., that make it difficult to reverse the commitment process. Scheff's investigation of commitment procedures thus leads him to conclude that "the official societal reaction . . . exaggerates both the amount and degree of deviance," and once the official process is initiated the person is almost invariably routed to a mental hospital (Scheff, 1966:154).

In summary, Scheff views mental illness as an ascribed status, entry into which is primarily dependent upon conditions external to the individual. His formulation is (1) that virtually everyone at sometime commits acts that correspond to the public stereotype of mental illness; (2) if, by some happenstance, these acts become public knowledge, the individual may, depending upon various (unspecified) contingencies, be referred to the appropriate officials; and (3) once this happens the person will be routinely processed as mentally ill and placed in a mental institution. This is an original formulation which very neatly gets around a potentially troublesome aspect of the societal reaction perspective, namely, why does the person commit an act of primary deviance? In most cases it would be very difficult to argue that the person publicly presents psychiatric symptoms for personal gain or because he belongs to a subculture with values in conflict with the dominant group. Instead, Scheff argues that psychiatric symptoms are a common phenomenon, that their presentation is unintended, and only rarely and fortuitously do they cause someone to be labeled mentally ill. The question we must now confront is whether or not this formulation is consistent with available evidence.

The Empirical Evidence. A number of investigations (Star, 1961; Nunnally, 1961; Cumming and Cumming, 1957) have been made of the public's image of mental illness. These studies indicate that the public lacks accurate knowledge about mental disorder, distorting and exaggerating the amount and type of disturbance. In addition, "the mentally ill are regarded with fear, distrust and dislike" (Nunnally, 1961:46). In the public conception, mental illness appears to involve unpredictable and potentially dangerous behavior. Furthermore, there is a halo effect: once a person is perceived as mentally ill, he is not only thought to be unpredictable and dangerous but also "dirty, unintelligent, insincere and worthless" (Nunnally, 1961:233). These investigations clearly indicate that the public has a negative, highly stereotyped image of mental illness and suggest

⁶ At this point Scheff's argument appears to me somewhat inconsistent. I find it difficult to associate a stereotype that is well-established and continually reinforced with a set of diverse behaviors (acts of residual deviance) whose primary similarity is that no explicit label can be attached to them. For a more detailed discussion of this problem see Fletcher and Reynolds (1968).

that the public generally views mental illness as a master status that overrides other characteristics of the individual. The question, however, is whether people are treated as mentally ill because they inadvertently perform an act that activates the stereotype of mental illness. The evidence from field surveys and from studies of the path to the mental hospital indicates that this is not the case.

In a pioneering study, Yarrow *et al.* (1955) investigated how wives came to define their husbands as mentally ill. The research demonstrated that the wives utilized strong defenses to avoid seeing their husbands' behavior as deviant. The wives would make every effort to interpret their husbands' behavior as normal. If that failed, they would minimize the importance of the behavior and balance it off against more normal behavior. Only when the husband's behavior became impossible to deal with⁷ would the wife take action to have her husband hospitalized. Even at this time the husband was not always viewed as mentally ill.⁸ This pattern appears to be consistent with the findings of other investigators (Schwartz, 1957:290; Sampson *et al.*, 1964; Hollingshead and Redlich, 1958; also see Jaco, 1960:18). Furthermore, investigations have indicated that rehospitalization does not typically occur because of the expectations of others but because of the manifestation of severe psychiatric symptoms which have become impossible to handle in the community (Freeman and Simmons, 1963; Angrist *et al.*, 1968).

The results of field surveys also bear upon how people identify the mentally ill. When

people are presented with descriptions of persons with various types of mental disorder, the disturbed behavior is not regarded as an indication of mental illness except when the person is presented as dangerous (Star, 1961; Cumming and Cumming, 1957). Phillips (1963), using the same case materials, has shown that rejection of the mentally ill is not related to their behavior⁹ but to their being labeled as mentally ill by being in treatment. In sum, the evidence strongly suggests that persons, typically, are hospitalized because they have an active psychiatric disorder which is extremely difficult for themselves¹⁰ and/or others to handle. It would appear that the public's stereotype of mental illness does not lead to persons being inappropriately labeled mentally ill through an inadvertent act of residual rule-breaking. Instead, the evidence suggests that the gross exaggeration of the degree and type of disorder in the stereotype fosters the denial of mental illness, since the disturbed person's behavior does not usually correspond to the stereotype.

Once a person is brought to the attention of public officials as mentally ill, do the officials, as Scheff suggests, act on the assumption of illness and routinely route him to a mental hospital? We might first look at persons who voluntarily seek hospitalization. Mechanic (1962) and Brown (1961:60) feel that public mental hospitals accept virtually all such patients, but they present no data. To my knowledge there are only two studies that have systematically evaluated hospital acceptance of voluntary mental patients. Mishler and Wexler (1963) found that the public mental hospital they studied accepted for admission only 39% (n=246) of the applicants, and the private mental hospital accepted 58% (n=137) of the applicants. Similarly, Mandel and Rapport (1969) found that the public mental hospital they studied accepted for admission 41% (n=269) of the applicants. Both studies thus found that the public mental hospitals only admitted approximately 40% of the voluntary applicants. Although there probably are hospitals that rou-

⁷ In the example provided by Yarrow *et al.* (1955), the husband, in a two-day period, thought a TV program was about him and the set was after him, threatened to kill his wife, got the shakes, kept his wife up and talked to her all night in a bizarre fashion (for example, he asked her if she were his mother or God), created a serious disturbance where his wife worked, said his male organs were blown up and little seeds covered him, and finally chased his wife around the apartment growling like a lion.

⁸ After a persons is hospitalized, he is not necessarily perceived by himself or others as mentally ill. Yarrow, *et al.* (1955) found that even after the husband's hospitalization one fifth of the wives did not view their husbands as mentally ill and another fifth did so only sporadically. The wives Schwartz (1957) studied also tended to deny their husbands were mentally ill. Scheff (1966:86) himself notes many hospitalized patients deny they are mentally ill, and a group of ex-mental patients which I studied (Gove and Lubach, 1969) generally acknowledged they had needed and benefited from hospitalization but denied they had been mentally ill. Also see Cumming and Cumming (1965).

⁹ The exception again is the paranoid schizophrenic who appears dangerous.

¹⁰ As state hospitals improve, an increasing proportion of patients seek voluntary admission. For example, Northern State Hospital, located in the State of Washington, has shown a marked improvement over the years, and the admission rate rose from 3% in 1955 to 57% in 1967. A study (Gove, 1968) of a sample of these patients found that most of the voluntary patients initiated their own hospitalization due to their acute distress (and occasionally disorientation), a reason for hospitalization not readily explained by the societal reaction perspective.

CHART 1. OUTCOME OF THE PSYCHIATRIC EXAMINATION

Wilde (1968:216-17)		Recommendation of Examiners		
		Release ^a	Commit	N
		4.8% (200)	95.2% (4000)	4200
Haney and Michielutte (1968) ^b				
	Examiners' Evaluation of Prospective Patients			
		Temporarily		
Age	Competent	Incompetent ^c	Incompetent	N
up to 64	35.7% (158)	13.6% (61)	50.0% (221)	442
65-over	8.5% (11)	3.1% (4)	88.4% (129)	129
Total	29.6% (169)	11.4% (65)	59.0% (337)	571
Kutner (1962)		Recommendation for Examiners		
		Release	Commit	N
		33%	77%	not given
Scheff (1968:284) ^d				
		Recommendation of Examiners		
	Release	30 Day Observation	Commit	N
	7.7% (2)	23.1% (6)	69.2% (18)	26

^a Over half of the requests for commitment came from psychiatrists. If we assume that the court psychiatrists in such cases agreed with their colleagues, then in those cases where the proceedings were initiated by a layman, the proportion of persons for whom commitment is recommended drops to about 90%.

^b Although the authors do not explicitly say so, the examining board apparently had the power not only to examine but also to commit.

^c The authors do not indicate whether or not persons judged to be temporarily incompetent were to be committed to a mental hospital.

^d Elsewhere Scheff (1968:281) notes that in the examination of 196 court records there was not a single recommendation for release (he does not indicate the outcomes of these hearings). This may be taken as an indication of an almost uniform presumption of illness, but it may be the case that when the psychiatrists recommend the person be released, the officials try to settle out of court by getting the participants to agree to the release of the subject.

tinely assume illness and admit virtually all voluntary mental patients, it is clearly inappropriate to assume this is always or even usually the case.

Let us turn to involuntary patients. Such persons may be thought of as going through three stages in their contact with public officials: (1) a screening stage where the police or some other screening agency makes the decision to hold or not to hold the person for examination and possible commitment, (2) an examination by a court psychiatrist or other duly qualified board and (3) the court hearing where the official decision is made to release the person or to commit him to a mental hospital.

First, let us examine the limited data available on the screening stage. A recent study of police discretion in the apprehension of the mentally ill by Bittner (1967:280) found that the police "like everyone else avail themselves of various forms of denial when it comes to doing something about it (mental illness)." Furthermore, it is Bittner's impression that "except for cases of suicide attempts, the decision to take someone to the hospital is based upon overwhelmingly conclusive evidence of illness" (Bittner, 1967:285). He goes on to note that the police regularly assist persons in the community whom they and others recognize

as having a serious mental disturbance while making no effort to have them hospitalized. There is, to my knowledge, only one study (Wilde, 1968) of a psychiatric screening agency that presents the agency's response to requests to initiate commitment proceedings. In this study when a nonpsychiatrist made a request to initiate commitment proceedings, the screening agency approved the request in only 33% of the cases ¹¹ (n=6000). In contrast, when a psychiatrist made a request, the request was apparently routinely approved—the approval rate for hospital psychiatrists being 98% (n=2000), and for court psychiatrists 100% (n=250)—presumably on the assumption that the psychiatrist had carefully and expertly evaluated the need for hospitalization. Support for this assumption is provided by the fact that the court psychiatrists examined approximately 1000 suspected mental cases sent by the jails but only requested commitment proceedings on 250 (Wilde, 1968:216). These studies clearly sug-

¹¹ Wilde (1968), from a study of a sample of persons processed by the screening agency, came to the conclusion that there was no relationship between degree of disturbance and the initiation of procedures. His study, however, suffers from methodological problems, and it can be shown that his conclusion is probably erroneous (see Gove, 1970).

gest that during the initial screening stage officials do not assume illness but in fact proceed rather cautiously, screening out a substantial number of persons.

Let us shift to the outcomes of the psychiatric examination of persons held for commitment. Scheff in his study of these examinations found them to be unsystematic, arbitrary, and prejudicial. He felt that "except in very unusual cases, the psychiatric examiner's recommendation to retain the patient is virtually automatic" (Scheff, 1968:287). Nonetheless, in each of the studies reviewed, release was recommended for at least some persons (see Chart 1). Generally, such recommendations were relatively rare; however, in the largest study (Haney and Michielutte, 1968) only 50% of the persons under 65 were found to be incompetent.

When we look at the outcome to the court hearing, we find a similar pattern with most, but usually not all, persons being committed (see Chart 2). The description of commitment proceedings (Miller and Schwartz, 1966; Wenger and Fletcher, 1969; Scheff, 1967) indicate that they are very rapid, that there is rarely any real exploration of the facts surrounding the case, and that proper legal procedures are not closely observed. From their experience Miller and Schwartz (1966:34) guess that "the judgment about mental illness had already been made earlier in the commitment process and that the hearing was a rubber stamp to an earlier decision." From the rates presented by Wilde (1968), it would appear that those persons who are released are exclusively those for whom the psychiatrists had recommended such action. Wenger and Fletcher (1969:68) explicitly state this to be the case in their

study. Miller and Schwartz (1966:34), however, found that "the judge reversed the medical recommendation for commitment . . . in nearly one-fourth of the cases."

In summary, the available evidence on how people enter the mentally ill role indicates that the societal reaction formulation, at least as stated by Scheff, is false. The evidence is that the vast majority of persons who become patients have a serious disturbance, and it is only when the situation becomes untenable that action is taken. The public officials who perform the major screening role do not simply process all of the persons who come before them as mentally ill but instead screen out a large portion. If the person passes this initial screening, he will probably be committed, and there is reason to assume the process at this point frequently becomes somewhat ritualized. But even here a number of persons are released either through the psychiatric examination or the court hearing.

CONSEQUENCES OF HOSPITALIZATION

Let us now turn to what happens to a person who enters a mental hospital. As noted in the introductory section, the societal reaction theorists feel that once a person has gone through a public hearing, and has been certified as a deviant and placed in an institution, it is extremely difficult for the person to break out of his deviant status. For a number of reasons, the impact of this process is held to be especially pronounced for the mental patient (see Goffman, 1961). First, the mental patient may have been misled, lied to, jailed and testified against by those he trusted; and by the time he arrives at the hospital, he is presumed to feel deserted, betrayed and estranged from his family and friends, a condition that should promote the acceptance of the mentally ill role. Second, in the hospital the patient is surrounded by severe restrictions and deprivations which are presented as "intended parts of his treatment, part of his need at the time, and therefore an expression of the state his self has fallen to." (Goffman, 1961:149). Third, the events recorded in the patient's case history are selected in such a manner that they are almost uniformly defamatory and discrediting. These events tend to be public knowledge, and they may be used to keep the patient in his place and to validate his mental illness.

Unfortunately, the research in the societal reaction tradition dealing with the effects of hospitalization has focused almost exclusively on what goes on in the hospital. Such studies have probably focused primarily on long-term patients who make up the bulk of the resident popula-

CHART 2. OUTCOME OF COURT HEARINGS

Wilde (1968:216-17)		
Proportion of Cases		
Released		Committed
4.8% (200)		95.2% (4000)
Miller and Schwartz (1966)		
Proportion of Cases*		
Released	Held Over	Committed
22% (13)	10% (6)	68% (39)
Wenger and Fletcher (1969)		
Proportion of Cases		
Released		Committed
19.7% (16)		80.3% (65)
Scheff (1967:113)		
Proportion of Cases		
Released		Committed
0% (0)		100% (43)

* Of the 58 prospective patients, 13 were voluntarily seeking admission.

tion; they tend to ignore the majority of psychiatric patients whose hospitalization is relatively brief. For this reason much of this research may present an unrepresentative picture. Let us agree, however, that mental hospitals may, in many ways, be debilitating places where patients *may* come to accept the preferred role of the insane and *may*, over time, develop skills and a world view adapted to the institutional setting and gradually lose their roles and even interest in the community.¹²

Restitutive Processes. The fact that debilitating processes may be present does not mean that restitutive processes are not also in operation. One such process may of course be treatment, but that is not the only one. An important study by Sampson *et al.* (1961, 1964), which looked at the patient before, during, and after hospitalization, found that hospitalization initiated major restitutive processes, most of which were not consciously guided by hospital personnel. Let us outline these processes. It was found that hospitalization interrupted a situation which was experienced as untenable and, by doing so, it blocked actions which threatened irremediable damage to family life. This interruption was "legitimated by the act of hospitalization which ratified the wife as ill and in need of special isolation and treatment" (Sampson *et al.*, 1961:144). This ratification of illness was decisive in blunting and redefining the negative implications of the interruption. The acts leading to the hospital were not viewed as alienative, "but as actions of an involuntary nature required by and serving the present and future interests of the patient and her family" (Sampson *et al.*, 1961:144). Furthermore, through moral and legal obstacles the husband was forced to defer a sometimes planned divorce allowing other solutions to marital difficulties to be considered and attempted.

As hospitalization occurred "at a relatively late stage in family and personal disorganization" (Sampson *et al.*, 1961:143), frequently a number of alienative acts had occurred which seriously jeopardized the resumption of the marriage. In such situations a certain "undoing" must be accomplished if the marital family is to be restored. Hospitalization was found to facilitate this "undoing" by a number of processes.

¹² A study by Wing (1962) of the effects of prolonged institutionalization on the mentally ill found length of hospitalization was associated with a growing apathy towards events outside the hospital and with an increased contentment with institutional life. However, contrary to what one might expect, if one felt that psychiatric symptoms were primarily a response to cues in the immediate environment, prolonged hospitalization was not associated with changes in symptomatic behavior.

(1) It enabled the patient and family to separate the deviant behavior and ideation from the real self of the patient. (2) Treatment was interpreted as an important and successful "undoing" process. According to Sampson *et al.* (1961:148), "patients and their spouses often assigned remarkable diagnostic acumen and therapeutic efficiency to the hospital, and they strained to view their eventual release as a carefully determined medical judgment of recovery." (3) During and following hospitalization there was a transition period of construction where the family evolved a new "working consensus." During this period, as is consonant with the concept of illness, relatives were advised not to upset the patient, and they in fact tended to avoid touchy subjects.

Hospitalization was also found to have initiated processes which served in a positive way to move the family toward reintegration. In some cases the removal of the patient and the conflict situation promoted a revival of positive ties and feelings. In many other cases the dislocation in family life produced by the wife's absence caused considerable problems and "at the first sign of improvement the husband often began to pleausurably anticipate his wife's return and resumption of responsibilities." (Sampson *et al.*, 1961:152). Furthermore, the hospital, by treating the husband as responsible for his wife and eager for her recovery, put him into a role which frequently reinstituted a relationship of concern and improved marital communication.

A major issue is whether the processes just presented generally have a major impact on the patient or if they are overshadowed by the processes pointed to by the societal reaction theorists. Before the era of the tranquilizers and the open door policy, the average patient was probably heavily influenced by the deadening institutional procedures of the traditional mental hospital. Now, however, the vast majority of mental patients receive fairly rapid and intensive treatment.¹³ In such cases the restitutive factors of hospitalization may well dominate; and, in any case, with a brief hospitalization the impact of many of the processes outlined by the societal reaction theorists should be minimal.

Stigma. There is, of course, the possibility that the patient is so stigmatized by having been labeled mentally ill that when he returns to the community he is not *allowed* to resume his previous interpersonal and instrumental

¹³ For example, in the State of Washington the median length of stay for the admissions to the state mental hospitals was only 2.0 months in 1966 (State of Washington, 1966).

roles. In an attempt to evaluate the question of whether or not the stigma of having been a patient in a mental hospital necessarily leads to the chronic occupancy of the mentally ill role, let us turn to a detailed study of 287 women after treatment conducted by Angrist *et al.* (1968). Their sample of women tended to be severely disturbed but to have an acute rather than chronic illness (for example, only one third of their sample had been hospitalized previously). Their patients had received fairly intensive treatment and on the average had been in the hospital 52 days. The study was concerned with those patients who had been returned to the community and who were able to remain there for 15 days.

One of the first things to be noted is that the ex-patients were not like their neighbors, or like a random sample of females in the community, the ex-patients being atypical in their lack of education, their singleness, and their household living arrangements. These factors apparently predated their hospitalization and could not be considered a consequence of being publicly labeled mentally ill. Once the former mental patients and their neighbors were matched on these characteristics, the groups were extremely similar "in the areas of instrumental role performance, role expectations and tolerance of deviant behavior" (Angrist *et al.*, 1968:161). The ex-patients, however, manifested significantly more psychiatric handicaps. The authors also found that "as performance (or the ability to perform) degenerates, the expectations of family members are corroded, so that they become accustomed to expect less of their relative" (Angrist *et al.* 1968:171). This suggests that expectations for poor performance may be determined more by ineffectual behavior than the reverse, a conclusion that appears to be consistent with the work of Freeman and Simmons (1963).

For former patients, probably the most important indicator of continued occupancy of the mentally ill role is rehospitalization. Of the patients in this study 15% had been rehospitalized after six months; 24% after two years; and 32% after seven years (Angrist *et al.*, 1968: *passim*). Thus, over two-thirds of these patients had not been rehospitalized after seven years, and probably a significant proportion of these never will.

What caused rehospitalization? The evidence indicated that following the initial hospitalization, the readmitted patients had exhibited more deviant behavior and more psychiatric symptoms (particularly extreme and acutely disordered symptoms) than ex-patients who avoided rehospitalization. Furthermore, the data showed that in spite of the fact that ex-patients

had previously been labeled as mentally ill, the relatives viewed "readmission as a last resort for behavior which cannot be handled without medical help" (Angrist *et al.*, 1968:100). In conclusion, the authors (Angrist *et al.*, 1968:176) state that "the fact that the returnees were decidedly sicker than community patients indicates that intrinsic features of the illness are of greater consequence in precipitating readmission than are the variations in the way significant others perceive, evaluate or tolerate such illness."

Although this study clearly suggests that the stigma attached to a former mental patient does not generally have serious consequences, it does not specifically deal with the question of stigma. Unfortunately, very little work has focused directly on this issue. A study of psychiatric patients by Jones *et al.* (1963) found that patients, typically, felt that the lay public would not view a person as undesirable because he had been in a mental hospital. Cumming and Cumming (1965) found, in a study of 22 former mental patients, that 41% felt stigmatized, four expressing shame and five having a generalized expectation of discrimination. They suggest that with the passage of time, or with the occupancy of normal roles, feelings of stigma will disappear. Freeman and Simmons (1961) in a study of feelings of stigma by relatives of ex-mental patients found that only 24% of the families ($n=394$) felt stigmatized. Furthermore, their findings indicate that feelings of stigma are associated with the perception that the patient is acting in an abnormal fashion and with a fear that persons in the community will discriminate against the family because of the patient's current bizarre behavior. In general, the evidence on stigma, although far from conclusive, suggests that stigma is not a serious problem for most ex-mental patients and that, when stigma is a problem, it is more directly related to the person's current psychiatric status, or general ineffectiveness, than it is to having been in a mental hospital.

DISCUSSION

The societal reaction perspective does not view the deviant as someone who is suffering from an intra-personal disorder but instead as someone who, through a set of circumstances, becomes publicly labeled a deviant and who is forced by the societal reaction into a deviant role. In essence, they view the deviant as someone who is victimized (see Gouldner, 1968). The available evidence, however, indicates that the societal reaction formulation of how a person becomes mentally ill is substantially incorrect. There is very little systematic evi-

dence of victimization. The evidence shows that a substantial majority of the persons who are hospitalized have a serious psychiatric disturbance quite apart from any secondary deviance that may be associated with the mentally ill role. Furthermore, persons in the community do not view someone as mentally ill if he happens to act in a bizarre fashion. On the contrary, they persist in denying mental illness until the situation becomes intolerable. Once prospective patients come into contact with public officials, a substantial screening still occurs, presumably sorting out persons who are being railroaded or who are less disturbed. It is only in the last stages of the commitment process that some ritualization appears to occur, and even here a noticeable proportion of persons are sorted out.

The evidence also indicates that the societal reaction theorists have overstated the degree to which secondary deviance is associated with mental hospitalization. (1) There appear to be many restitutive processes associated with hospitalization even apart from the question of therapy. (2) Patients treated in a modern psychiatric hospital typically do not spend enough time in the hospital to become truly institutionalized. (3) In most cases the stigma of having been a former mental patient does not appear to affect greatly one's performance in the community following discharge. In summary, the studies reviewed, while in no way denying the existence of the processes outlined by the societal reaction theorists, suggest that mental hospitalization does not necessarily or even typically lead to a prolonged occupancy of the mentally ill role. Furthermore, the available evidence indicates that when former patients continue to have difficulty, these difficulties are generally due to the person's confronting a troubled situation or to some psychiatric disorder, and not to the social expectations of others.

It would appear, from what we know of mental illness, that it is useful to make a distinction between primary and secondary deviance. However, contrary to the position taken by the societal reaction theorists, the primary deviance may reflect a serious disturbance, one that in some cases may be considerably more important than the problems associated with secondary deviance. Most of the hospitalized cases of mental illness appear to reflect a psychiatric disorder that requires societal intervention (treatment). If the treatment is rapid, intensive, and effective, the psychiatric crisis can be handled without any significant development of secondary deviance (see for example Gove and Lubach, 1969). Clearly in the past a great deal of secondary deviance was produced by

mental institutions. However, mental hospitals have moved a long way from the traditional insane asylum, and the amount of secondary deviance has been greatly reduced.¹⁴

The inability of the societal reaction theorist to explain the development of mental illness together with their exaggeration of the amount of secondary deviance produced by treating someone as mentally ill is probably indicative of a general bias in the perspective. The societal reaction perspective does not explain why people initially commit deviant acts; it deals mainly with secondary processes that may not always be of crucial importance. Just as focusing only on the processes involved in producing primary deviance may lead to an unrealistic image of a deviant behavior, so also will an exclusive focus on the societal reaction to an act of primary deviance.

The evidence reviewed suggests that a person's behavior determines the expectations of others to a much greater degree than the reverse. This relationship between behavior and expectations is probably generally true in the short run; it certainly appears that it is the person's disturbed behavior that generally leads to the mentally ill role. In the long run, however, the expectations of others may play an important role in determining the behavior of a person, and such expectations should be taken into account in a general theory of mental illness.¹⁵ Unfortunately, the societal reac-

¹⁴ Modern mental hospitals, however, still have demonstrable detrimental effects (see for example Pasamanick *et al.*, 1967).

¹⁵ As has been shown, a focus on the expectations of others does not in general lead to an explanation of why someone becomes mentally ill. However, whether or not a person who is mentally ill remains mentally ill may depend in part on the social expectations he confronts. Let me, as an illustration, indicate one way in which the expectations of others would appear to relate to mental illness. As a general rule, people normalize the behavior of others; i.e., they interpret it in light of the situation and the person's past behavior. If in the past a person has acted in a normal (appropriate) fashion and then, for a brief period, acts inappropriately, others will tend to normalize his behavior (see it as being within the bounds of normality). However, if the person has a long history of inappropriate behavior and then starts to act in an appropriate fashion, others will again normalize his behavior (still see him as inappropriate). Thus, although it is the psychiatric disturbance of the individual that generally places a person in the mentally ill role, once he becomes firmly entrenched in that role (the evidence would indicate that a single brief psychiatric hospitalization is generally not sufficient for this), the expectations of others may make it very difficult to leave it. Elsewhere I am presenting in considerable detail the relationship between social expectations and mental illness (Gove, 1970).

tion theorists have generally treated their framework as a sufficient explanatory system. In doing so they have underemphasized the importance of acts of primary deviance and overemphasized the importance of the forces promoting secondary deviance.¹⁶ Future attempts at explaining mental illness will have to redress the balance.

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¹⁶ For example, I suspect that they have generally overstated the difficulties a stigmatized person will have when dealing with the public. Such findings are reported in the literature. Kitsuse (1964:100), for example, would on theoretical grounds posit "extreme negative sanctions against homosexuality" but found his subjects to have "generally mild reactions."

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THE ORGANIZATION OF ROLE-RELATIONSHIPS: A SYSTEMATIC DESCRIPTION *

GERALD MARWELL AND JERALD HAGE

University of Wisconsin

Two sets of raters independently scored 100 role-relationships on 16 general variables. Factor analyses of these two sets of ratings produced similar factor structures defined by three major factors. These factors were interpreted as reflecting the "intimacy," "visibility," and "regulation" of the role-relationships. Eight types of role-relationships emerge from a cross-classification of these three factors, after dichotomization. Some of the structural pressures underlying the appearance of various role-relationships in each of these types are discussed. Particularly important seem to be variations in the kinds of social control most relevant to different role-relationships.

THERE is a history in the discipline of concern with distinguishing among types of social relationships, even if there have been few relevant empirical studies. Toennies' (1957)

distinction between *gesellschaft* and *gemeinschaft* is, as Nisbet (1966) notes, perhaps the most lasting terminology. Communal vs. associative (Weber, 1947); mechanical vs. organic (Durkheim, 1933); particularistic vs. universalistic and the other pattern variables (Parsons, 1951) are alternative or supplementary distinctions prominent in the literature.¹

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¹ It might be noted that Durkheim's distinction between mechanical and organic solidarity refers more to the basis than to the kind of social rela-